STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

FEBRUARY 26, 2014

Good morning, Chairman Benishek, Ranking Member Brownley, and members of the Committee. Thank you for the opportunity to discuss the progress made regarding the Veterans Health Administration's (VHA) physician staffing and productivity standards, treatment for Veterans who experienced military sexual trauma, pain management programs, and procurement reform. I am accompanied today by Dr. Robert Jesse, Principal Deputy Under Secretary for Health, Dr. Madhulika Agarwal, Deputy Under Secretary for Health for Policy and Services, Dr. Rajiv Jain, Assistant Deputy Under Secretary for Health for Patient Care Services, and Mr. Philip Matkovsky, Assistant Deputy Under Secretary for Health for Administrative Operations.

The Department of Veterans Affairs (VA) is committed to providing the highest quality care, which our Veterans have earned and deserve. VA operates the largest integrated health care delivery system in the country, with over 1,700 sites of care. It is important to acknowledge that each year, over 200,000 VHA leaders and health care employees provide exceptional care to approximately 6.3 million Veterans. The high quality health care VA provides is consistently recognized by The Joint Commission and other internal and external reviews.

I want to address the issue of accountability. The Veterans Health Administration is the largest integrated health care system in the country, providing 85 million total health care appointments last year and 25 million consultations at more than 1,700 VA health care sites. Allegations of misconduct by employees are taken seriously. When we learn of credible allegations of misconduct, VA addresses them immediately.

When incidents occur, we identify, mitigate and prevent additional risks. Prompt reviews prevent similar events in the future and hold those responsible accountable. If

employee misconduct or failure to meet performance standards is identified, VA takes the appropriate action.

I would point out that VA appreciates and values the role that Congress, this Committee, VA's Office of the Inspector General (OIG), the Office of Special Counsel, and the Government Accountability Office have played in identifying areas where the VHA can improve. VA utilizes their insights when forming policy and taking action to strengthen our healthcare delivery programs.

Care and Treatment Available to Survivors of Military Sexual Trauma

Effectively treating Veterans who experienced military sexual trauma (MST) continues to be a top VA priority. We are committed to ensuring that appropriate MST services are available to meet the treatment needs of both men and women Veterans. Rates of engagement in care and the amount of care provided have increased every year that VA has monitored MST-related treatment. In fiscal year (FY) 2013, 93,439 Veterans received MST-related care at VHA. This is an increase of 9.3 percent (from 85,474) from FY 2012. These Veterans had a total of 1,027,810 MST-related visits in FY 2013, which represents an increase of 14.6 percent (from 896,947) from FY 2012.

At last year's hearing on care and treatment available to survivors of MST, we discussed VA initiatives to provide counseling and care to Veterans who experienced MST; monitor MST-related screening and treatment; provide VA staff with training; and inform Veterans about available services. Since that hearing, VHA has made significant improvements in these areas. VA has implemented improvements in MST care to include enhanced screening, expanded telemental health services, and expanded guidance.

As discussed during the hearing, VHA has a universal screening program for MST. A Clinical Reminder in the electronic medical record alerts providers of the need to screen the Veteran, provides language to use in asking the Veteran about MST, and documents the Veteran's response to the screen. Because a revision of the MST Clinical Reminder will be rolled out by the end of FY 2014, VHA will implement several changes including changing the Clinical Reminder language to make the questions asked more readily understandable to Veterans. Also, an explicit option to "decline" has

been added, to allow Veterans to choose when and with whom they would prefer to disclose their experience. Veterans who "decline" are automatically re-screened again in a year. Although the intent of these changes is to facilitate disclosure, the revised Reminder language also capitalizes on screening as an opportunity to provide all Veterans with information about VHA's specialized MST services, regardless of whether or not they disclose having experienced MST. Veterans who express interest in MST-related treatment will have streamlined access to care via an option in the Reminder itself to initiate a referral for services.

In conjunction with the rollout of the revised Clinical Reminder, VHA has engaged in efforts to provide staff with additional training on how to screen and respond sensitively to disclosures of MST. National educational resources have also shifted to clarify the importance of creating multiple opportunities for disclosure of experiences for MST – for example, re-screening all Veterans who are seen in clinics for posttraumatic stress disorder (PTSD) or other specialty services.

The addition of the referral question to the Clinical Reminder will allow for increased accountability with respect to the MST-related treatment provided by VHA. First, it will provide national monitoring data that will allow VHA to track whether Veterans who request MST-related mental health services are able to access those services. Second, it will allow VHA to establish benchmarks for what percent of Veterans (on average) might be expected to access MST-related care after screening positive. Veterans who screen positive for MST will vary in their need and interest in MST-related treatment through VHA; without some indication of what percent of Veterans are interested in treatment, it is currently difficult to know the extent to which VA is reaching the subset of Veterans who actually need care.

Given the increases in MST-related treatment mentioned earlier, it is important to ensure that facilities have adequate capacity to meet the demand for care. Analyses conducted by VHA's national MST Support Team established a minimum staffing benchmark of 0.2 full time equivalent employees per 100 Veterans who screen positive for MST. Annual monitoring of all VHA facilities using this benchmark demonstrated a positive impact on the availability of services. These analyses, in conjunction with the new referral question associated with the Clinical Reminder, will assist VHA in

assessing continued progress towards the goal of ensuring that all Veterans who would benefit from MST-related care are able to readily access that care.

During the previous hearing on MST, we discussed the geographic challenges some Veterans face when seeking to access care. VHA is providing services via information and telecommunication technologies that give Veterans more options and have improved access to care. Telemental health approaches can be used to treat most every mental health condition and deliver all Evidence-based Psychotherapies (EBP). As part of its strong commitment toward providing high quality mental health care, VHA has nationally disseminated and implemented specific EBPs for PTSD and other mental and behavioral health conditions. Because PTSD, depression and anxiety are commonly associated with MST, these national initiatives are important means of expanding MST survivors' access to treatments. Furthermore, several of these treatments were originally developed to treat sexual assault survivors and have a particularly strong research base with this population.

Veterans who experienced MST can receive EBPs at every VA medical center and increasingly via telehealth. VHA's work in this area is supported by recent research, including research conducted within VHA that has shown these therapies to be effective and well-accepted by patients when delivered. VA administrative data indicates that from FY 2011 to FY 2013 psychotherapy telemental health encounters with Veterans with primary diagnosis with PTSD has increased more than 3-fold and during the same time frame, the number of unique Veterans with primary diagnosis of PTSD receiving psychotherapy via telemental health has more than doubled. This is due in part to national VHA efforts to expand the use of telehealth to providing care, particularly to Veterans with PTSD.

In September, an Information Bulletin was distributed to Veterans Integrated Service Network (VISN) leadership that provided guidance on the importance of protected time for the MST Coordinator, ensuring facilities have sufficient capacity to provide MST-related care, and clarification that non-VA (fee basis) care can, and should, be provided when there will be a delay in the facility's ability to meet a Veteran's treatment needs, or if it is otherwise clinically indicated for the MST-related care to be delivered at a non-VA facility. The Information Bulletin also underscored the need to

ensure adequate services are available to meet the needs of male Veterans who experienced MST and that these services are provided in a manner that recognizes some of the unique challenges men may face in accessing care and in their recovery more generally. The revised MST Clinical Reminder will include a mental health services referral question, which will streamline access to care for Veterans who express interest in MST-related treatment. In recognition of this, at a national level, MST is clearly defined as an issue of concern for both men and women, in that it has been under the administrative oversight of the national Mental Health Services program office since 2006.

In 2013, VHA concurred with the Office of the Inspector General's recommendation to review existing VHA policy pertaining to authorization of travel for Veterans seeking MST-related treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled. VHA agreed to establish a workgroup to review the issues and provide recommendations to the Under Secretary for Health. After reviewing current policies, the workgroup confirmed that currently, MST status does not in and of itself qualify Veterans for reimbursement of travel expenses (called Beneficiary Travel) and drafted an initial proposal discussing potential options for addressing this issue. The work group has been directed to conduct further analysis and reach consensus on a recommendation.

Department-Wide Acquisition Reform

The Subcommittee also hosted a number of roundtables to examine the impact Department-wide acquisition reform has had on access and quality of care for Veteran patients and opportunities to improve patient care in addition to the authority to bill and collect from third party health insurance companies. We discussed the processes used to provide non-VA care for Veterans and how billing was conducted following the care being delivered. We also discussed VA standards for claims payment and performance metrics used to track VA results as well as the consolidation of billing and the improvements and efficiencies recognized from the changes.

Since the roundtable discussions, the Department has expanded its use of authorities to acquire care from community health care providers. In January 2014, we

successfully launched delivery of healthcare through Patient Centered Community Care (PC3) contracts, beginning a phased deployment across the VA health care system. This new program employs nation-wide contracts to improve Veterans' access to quality health care. These contracts also standardize our referral, authorization and payment processes. Our phased deployment will achieve delivery of health care through PC3 across all VISNs in April of 2014.

VA completed its consolidation of billing through the Consolidated Patient Account Centers (CPAC) in September 2012. This effort was completed ahead of schedule, and has improved the reliability and performance of our billing and collection processes. Since our roundtable discussions we have conducted requests for information through the Federal government procurement system to identify commercial best practices for automation of health care billing systems. This approach was a direct result to the discussions conducted at the roundtable, and it allows our VA team to collect competitive information from numerous firms. We are now processing responses and assessing how best to further develop a solicitation to improve our automation of hospital billing.

Additionally, we met with the Health Subcommittee regarding claims payment timeliness. We have established a nation-wide effort to improve the timeliness of all claims VA pays to providers who provide authorized care to Veterans. We are currently working with our legacy systems and have increased oversight of our claims payment processes. We have partnered with our Department colleagues to develop a fully automated and commercial claims payment system that will enable improved and sustainable performance in our payment processes. This system is in field-testing in one of our networks and will complete development by the end of this calendar year, with a subsequent national roll-out and training for all our claims payment staff by the end of FY 2015.

We have welcomed the involvement from this Subcommittee during our roundtables, which has informed the continued improvements in our administrative processes.

Physician Staffing and Productivity Standards

At last year's hearing, we discussed how VHA was addressing productivity and staffing beginning with Primary Care Services followed by Radiology and Mental Health. We also discussed the complexities associated with measuring productivity in a health care setting. VHA reported in March 2013 that more than 54 percent of its physician workforce had standards in place to measure their productivity and efficiency.

Today, I am pleased to report that we are on target to deliver productivity and staffing standards for all VHA physicians by the end of FY 2014. In October 2013, VHA briefed the OIG on its progress on developing and implementing specialty physician productivity and staffing standards. Based on VHA's briefing, the OIG closed out its "Audit of Physician Staffing Levels for Specialty Care Services," OIG report 11-01827-36, in November of 2013. The work continues and we will not be finished until all physician specialty productivity and staffing standards are complete and ready access to high quality, efficient specialty care is available to our Nations Veterans

Today, I'd like to share with you some of the details of what we have accomplished and assure this Subcommittee of VHA's commitment to the results-oriented approach we have taken in accomplishing the implementation of physician productivity and staffing standards. VHA has adopted an activity-based productivity and staffing model for specialty physicians. Utilizing an industry accepted Relative Value Unit (RVU)-based model, specialty physician productivity standards have been developed and implemented. In FY 2013, productivity standards for six specialties (dermatology, neurology, gastroenterology, orthopedics, urology, and ophthalmology) were developed, piloted in four VISNs (VISNs (7, 12, 19 & 22)) and then implemented VHA-wide in FY 2013. All VISNs and medical centers were informed of the new productivity standards for the six physician specialties listed above on July 26, 2013. The standards were implemented VHA-wide on September 30, 2013. By the end of March 2014, VHA will have productivity and staffing standards in place for 25 different specialties representing more than 81 percent of its total physician workforce.

A critical component of the productivity and staffing standard implementation is the Specialty Productivity-Access Report & Quadrant (SPARQ) tool that provides an algorithm for the effective management of VHA's specialty physician practices. This

tool is designed to assess VHA specialty physician practice business strategies and drive performance improvement in Veteran access to specialty care. This tool was recognized by our OIG colleagues as one of the most important managerial tools developed in support of physician productivity and staffing standards and its ability to go beyond standard implementation to ultimately drive system performance.

The SPARQ tool includes important measures, such as support staff ratios for VHA specialty physicians so as to maximize physician efficiency. The SPARQ tool measures the care team, including advanced practice providers such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists, and their RVU contribution. The SPARQ tool also measures specialty physician value in the form of 'compensation per RVU' so as to demonstrate VHA's ability to be good stewards of public health care resources. Additional views for local medical center and VISN leadership have been added to permit a view of all specialties so that local leaders can make informed decisions about specialty care resources and be accountable for these decisions.

VHA has also undertaken a comprehensive education and communication plan about the specialty physician productivity and staffing standards. VHA has held national calls to actively engage its specialty physician workforce. VHA specialty physicians are committed to demonstrating and improving specialty productivity and access. VHA has also held national calls with its medical center leadership in an effort to clearly communicate the expectations of full implementation of specialty physician productivity and staffing standards. All medical centers have been provided with access to a variety of tools that permit productivity and staffing measurement at the individual physician and specialty practice level. Our national and local specialty leaders have been trained on the business strategies and tools available to assist them in managing their specialty practices with the goal of ready access to quality specialty care for our Veterans.

VA's Pain Management Programs and the Use of Medications to Treat Veterans

At last year's hearing, we discussed how VA is providing comprehensive and patient-centered pain management services to improve the health of Veterans. We also highlighted VA's current pain management strategies, the prevalence and use of opioid

therapy to manage chronic pain in Veterans who are potentially at increased risk for a medication-related adverse event such as someone taking a high dose of an opioid at the same time as taking a benzodiazepine medication,, the challenges of prescription drug diversion and abuse among Veterans, and the actions VA is taking to improve the management of chronic pain.

Today, we are providing an update on our progress and the on-going challenges that we are working on in order to provide the best care to our deserving Veterans when it comes to managing their pain. This includes the integration of both medications and non-pharmacologic evidence-based strategies.

Veterans enrolled in VA's health care system suffer from higher rates of chronic pain than the general population[1]. Almost 60 percent of Veterans returning from the Middle East and more than 50 percent of Veterans in the entire VA health care system experience some form of chronic pain. Many have survived severe battlefield injuries, resulting in life-long severe pain related to damage to their musculoskeletal system, as well as permanent nerve damage, which can impact their emotional health and brain structures. Many have also incurred head injuries, collectively referred to as traumatic brain injuries (TBI), which can compound psychological injuries such as PTSD. The extent and complexity of these multiple conditions can make effective pain management difficult and increase the risk for complications, due to both over-and under-treatment, including overdose and suicide.

In 2011, the Institute of Medicine (IOM) issued their report describing general deficits in the training of U.S. health care professionals in pain management. VA's health care system had identified and broadly responded to these deficits starting in the late 1990s through policy, education and training, clinical monitoring, and the expansion of clinical resources and programs. For instance, VA recognized that in the management of pain, and for mental health problems such as PTSD, that can accompany combat injury related pain, there may be value to non-medication treatment approaches, including evidence-based psychotherapy and complementary and alternative medicine (CAM) approaches such as meditation, animal-assisted therapies

[1] According to a 2010 Institute of Medicine estimate, the rate of chronic pain in the general population is approximately 32 percent.

and acupuncture. Several of these approaches are in active use and are under ongoing evaluation.

VA recently developed and implemented an Opioid Safety Initiative program to better ensure opioid pain medications are used safely, effectively and judiciously. The basis for this is to make visible the totality of opioid use at all levels, patient, provider and facility, in order to identify high-risk situations. The Opioid Safety Initiative includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average dosage per day of opioids such as hydromorphone, methadone, morphine, oxycodone, and oxymorphone. Patients at risk for adverse events from use of opioids are identified through the use of administrative and clinical databases using pre-determined parameters based on published evidence and expert opinion. Several aspects of the Opioid Safety Initiative were underway at the time of the October 10, 2013, hearing and have begun to bear positive results:

- Despite overall growth in the number of Veterans who were dispensed <u>any</u> medication from a VA pharmacy, between the quarter beginning in July 2012 compared to quarter ending in December 2013, 33,142 fewer Veterans received any opioid prescription (including short and long term use) from VA.

- Performing urine drug screens is a useful tool to assist in the clinical management of patients receiving long-term opioid therapy. Between the quarter beginning in July 2012 compared to quarter ending in December 2013, the number of patients on long term opioid therapy who have had at least one urine drug screen increased by 27,783, while the total number of patients on long term opioids decreased by 13,859.

- Whenever clinically feasible, the concomitant use of opioid and benzodiazepine medications should be avoided. Between the quarter beginning in July 2012 compared to quarter ending in December 2013, 10,664 fewer patients were receiving these drugs at the same time.

- Lastly, the average dose of selected opioids has begun to decline slightly in VA, demonstrating that prescribing and consumption behaviors are changing.

These facts signal an important downward trend in VA's prescribing of opioids. VA expects this trend to continue as it renews its efforts to promote safe and effective pharmacologic and non-pharmacologic pain management therapies. Very effective programs yielding significant results have been identified, and are being studied as strong practice leaders.

At the Tampa VA medical center, a safety-focused pain treatment program has been in place since 1988. The goal of the program is to replace the use of opioids for pain management with non-pharmacologic treatments such as behavior therapy, physical therapy, occupational therapy and/or kinesiotherapy. Tampa also has a long-standing process of identifying and conducting clinical reviews of Veterans who have received high morphine equivalent doses. At the Columbus, Ohio VA Outpatient Clinic, a Veteran-centered approach on opioid safety is focused on minimizing short acting opioids. This program has resulted in fewer Veterans on opioids with an 80 percent decrease in short acting opioid doses dispensed.

Current VA Pain Management Strategies

Many Veterans require a combination of strategies for the effective management of pain, including treatment with opioid analgesics, which are known to be effective for at least partially relieving pain caused by many different medical conditions and injuries. VA treatment involves 1) interrupting or moderating the pain signal from peripheral disease/damage (e.g., medications/injections, transcutaneous electrical nerve stimulation (TENS), acupuncture, and stimulation.); 2) supporting structures (e.g., spine) to reduce activation of pain signals (physical therapy and exercise to build strength and flexibility and help control weight); and 3) help the Veteran cope with pain and learn better self-management strategies (behavioral therapies).

In 2010, the Department of Defense (DoD) and VA jointly published evidence-based Clinical Practice Guidelines (CPG) for the use of chronic opioid therapy in chronic pain available on the internet. Guidelines reserve the use of chronic opioids for patients with moderate to severe pain who have not responded to, or responded only partially to,

clinically indicated evidence-based pain management strategies of lower risk, and who also may benefit from a trial of opioids. A toolkit has also been published and widely distributed to assist clinicians in using the Guidelines: (https://www/qmo.amedd.army.mil and http://www.healthquality.va.gov). VA has also developed and disseminated a patient education resource, entitled "Taking Opioids Responsibly", to increase Veterans' awareness of the risks and benefits of opioid treatment. More recently, the DoD-VA Pain Management Work Group (PMWG) of the VA-DoD Health Executive Council (HEC) has built upon the past work begun with the 2010 CPG and meets monthly to evaluate progress and improve effectiveness of projects focused upon the VA-DoD mission to improve pain management. These include two projects funded in 2013 and well underway: Joint Pain Education and Training Project (JPEP)", and "Tiered Acupuncture Training Across Clinical Settings (ATACS)."

To support a system-wide approach, VA disseminated guidance and tools to providers to communicate long term opioid therapy expectations. Among the tools and guidance are:

a. VA National Pain Management Strategy - VA has established pain management as a national priority. The objective of the strategy is a comprehensive, multicultural, integrated system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain. The strategy incorporates care by pain medicine, behavioral health, physical medicine and rehabilitation and other specialty providers to manage complex patients.
b. VHA Pain Management Directive - VA's Pain Management Directive defines and describes policy expectations and responsibilities for the overall National Pain Management Strategy and Stepped Care pain model.

In coordination with DoD, a multi-modality, team-based, stepped care model is being implemented throughout VA. VA and DoD have developed patient and provider educational materials and two Joint Incentive Fund sponsored initiatives are underway.

The Acupuncture Training Across Clinical Settings Project will create access to acupuncture for Veterans and Servicemembers in all clinical settings throughout VA and DoD.

Forty-eight states have implemented Prescription Drug Monitoring Programs (PDMP) as a means to improve the quality of care and prevent the diversion of controlled substances. Two additional states and the District of Columbia have enacted legislation to develop a PDMP or have legislation pending. VA published an Interim Final Rule to allow participation in these programs and is successfully transmitting data from six pilot sites to state PDMPs. The remaining VA facilities are scheduled to begin transmitting data by the end of FY 2014.

Non-pharmacologic Approaches to Treatment of Veterans' Mental Health Problems and Pain Management

The treatment of PTSD in VA follows the evidence-based recommendations of the Joint VA/DoD Clinical Practice Guideline for PTSD, most recently published in 2010 and accessible on the Internet at http://www.healthquality.va.gov/ptsd/. The first-line treatments for PTSD are evidence-based trauma focused psychotherapies such as Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) that have the highest level of evidence (Level A) indicating "a strong recommendation that the intervention is always indicated and acceptable."

In terms of medications, the Guidelines strongly recommend (Level A) selective serotonin reuptake inhibitors or serotonin norepinephrine reuptake inhibitors. To date, VA has provided training in Cognitive Processing Therapy and/or Prolonged Exposure to more than 6,000 VA mental health staff. All VA medical centers provide at least one of these therapies, as required in VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*. According to a 2011 VA survey, 89 percent of VA facilities offered CAM treatments, an increase from 84 percent in 2002. The most common types of CAM provided are meditation (72 percent of VA hospitals); Stress Management/Relaxation Therapy (66 percent); and Guided Imagery (58 percent); acupuncture (41 percent), and yoga (44 percent). The most common uses of

CAM are for stress management, anxiety disorder, PTSD, depression, back pain, and wellness-promotion.

The Acupuncture Training Across Clinical Settings Project is now in development to ensure, through standardized training of medical and battlefield acupuncturists, that all Veterans and Servicemembers in all clinical settings throughout VA and DoD have access to appropriate levels of acupuncture. VA has submitted a request for job classification to OPM for the hiring of certified acupuncturists.

VA and DoD combined VA's Health and Information Group survey of CAM modalities with the RAND survey of DoD Innovative Mental Health Programs as the foundation for a joint registry that will provide a record of innovative treatment programs. The combined list now includes over 700 programs and is a substantial initial step toward characterizing and tracking innovative treatment modalities.

Conclusion

As stated earlier, the Department of Veterans Affairs is committed to providing the highest quality care, which our Veterans have earned and deserve. Progress has been made regarding physician staffing and productivity standards, treatment for Veterans who experienced military sexual trauma, pain management programs, and procurement reform, and we will continue to seek improvement as we deliver high quality health care.

We will continue to identify, mitigate, and prevent vulnerabilities within our health care system, wherever we find them, and we will continue to ensure accountability and develop a culture in which accountability principles are clearly stated. And when adverse events do occur, we will identify them, learn from them, improve our systems, and do all we can to prevent these incidents from happening again.

Mr. Chairman, this concludes my testimony. I appreciate the Subcommittee's continued interest in the health and welfare of America's Veterans. At this time, my colleagues and I are prepared to answer your questions.